

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor Vista Medical Center Hospital 4301 Vista Rd. Pasadena, TX 77504	MDR Tracking No.: M4-04-1398-01
	TWCC No.:
	Injured Employee's Name:
Respondent The American Insurance Co. Rep. Box # 19	Date of Injury:
	Employer's Name: Wallaces Bookstores Inc.
	Insurance Carrier's No.: 67099913326

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10-3-02	10-14-02	Inpatient Hospitalization	\$34,954.29	\$6,432.90.

PART III: REQUESTOR'S POSITION SUMMARY

The Carrier has not provided the proper payment exception code in this instance, which in violation of the TWC Administrative Code. Healthcare provider does not have a negotiated contractual agreement with Carrier.

PART IV: RESPONDENT'S POSITION SUMMARY

The Requestor asserts it is entitled to reimbursement in the amount of 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed \$40,000 in total audited charges, but also involve "unusually extensive services."

The discharge summary indicates claimant underwent laminectomy and fusion with instrumentation. Postoperatively the patient was kept at bedrest. She was quite slow to ambulate. She had significant swelling in her back. The patient's Hemovac continued to drain. The patient underwent removal of her Hemovac on 10/6. The patient was found to have a positive culture of E. coli from her Hemovac drain...Patient subsequently became afebrile on 10/14/02."

After reviewing the documentation provided by both parties, it **does** appear that this particular admission involved "unusually extensive services." In particular, this admission resulted in a hospital stay of 11 days based upon E. coli infection.

The requestor billed \$66,891.18 for the hospitalization. In determining the total audited charges, it must be noted that the insurance carrier has indicated some question regarding the charges for the implantables. The requestor billed \$12,380.00 for the implantables. The actual cost for the implants per invoices was \$11,475.00 + \$4440.00 = \$15,915.00.

The requestor also billed \$5125.00 for a back brace, and actual cost was \$1025.00.

\$66,891.18 minus \$12,380.00 = \$54,511.18. This number minus charges for LSO back brace of = \$49,386.18. This number minus personal convenience = \$46.55 = \$49,339.63. Minus the insurance carrier's usual and customary charges reduction of \$34,179.16 = \$15,160.47.

Corvel's line by line audit audit charges = \$15,160.47 plus the \$17,506.50 (implantables cost + 10%) plus \$1127.50 (LSO back brace) = \$33,794.47.

Corvels' line by line audit raised issues of excessive charges, unbundling, not documented, and unrelated issues. The requestor did not submit persuasive documentation to challenge this audit. Since total audit charges **do not** exceed \$40,000, per diem reimbursement methodology applies.

Surgery /per diem for 11 days = \$12,298.00 + \$17,506.50 (implantables + 10%) + \$1127.50 (LSO back brace + 10%) = \$30,932.00.

The insurance carrier audited the bill and paid \$24,499.10 for the inpatient hospitalization. The difference between amount paid and due = \$6,432.90.

Based on the facts of this situation, the parties' positions, and the application of the provisions of Rule 134.401(c), we find that the health care provider is entitled to a reimbursement amount for these services equal to \$6432.90.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$6432.90. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Findings and Decision by:

Elizabeth Pickle

April 25, 2005

Authorized Signature

Typed Name

Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____